CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155673		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COI	(X3) DATE SURVEY COMPLETED 07/07/2011		
	PROVIDER OR SUPPLIER		p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP RACY ST E, IN46770	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K0000	and State Licent conducted by the Department of accordance with Survey Date: Of Facility Number Provider Number: Surveyor: Amy Code Specialist At this Life Safe Markle Health awas found not Requirements of Medicare/Medi Subpart 483.70 from Fire and the National Fire Association (NI Code (LSC), Chealth Care October 1AC 16.2. This one story determined to construction and story of the National Fire and the National Fire Association (NI Code (LSC), Chealth Care October 1AC 16.2.	h 42 CFR 483.70(a). 77/07/11 r: 000544 er: 155673 100267340 Kelley, Life Safety ety Code survey, and Rehabilitation in compliance with for Participation in caid, 42 CFR 0(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety apter 19, Existing cupancies and 410 facility was be of Type V (111)		0000	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YIQU21

Facility ID:

000544

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	A. BUILDI		STRUCTION 01	(X3) DATE S COMPLI 07/07/20	ETED
		100070	B. WING	STREET AT	DDRESS, CITY, STATE, ZIP CODE	01701720	J 1 1
NAME OF F	PROVIDER OR SUPPLIER				RACY ST		
	HEALTH & REHAE				i, IN46770		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
		he facility has a fire					
	alarm system w	-					
		e corridors, areas					
	open to the corridors and all						
	-	on the 300 hall.					
	The facility has	a capacity of 100					
	and had a cens	us of 67 at the time					
	of this survey.						
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/13/11. The facility was found not in compliance with the						
	aforementioned	d regulatory					
	requirements a	s evidenced by the					
	following:						
K0014 SS=F	including exposed buildings such as	orridors and exitways, interior surfaces of fixed or movable walls, s, and ceilings has a flame lass A or Class B.					
	Based on obser	vation and	K00	14	K 0014It is the practice of this facility to obtain documentation		08/06/2011
	interview, the f				for the flame spread rating of		
	· ·	entation for the			interior materials installed wit	hin	
	•	ating of interior			exit access.l. Corrective Acti		
		installed within			TakenFacility has a copy of the flame spread rating for the ca		
		4 of 4 corridors in			that was installed on the botto		
	the facility. Th	is deficient practice			third of the corridor walls		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	
		155673	B. WINC			07/07/2	U11
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
MADIZIE	HEALTH & REHAB	ULITATION!			RACY ST		
		-		WARKL	E, IN46770		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		·		IAG	throughout the facility.II.		DATE
	Environmental 3 07/07/11 durin 11:53 a.m. to 2 was installed of of the corridor the facility. Inte Environmental 3 time of observa documentation demonstrate the	e: vations with the Supervisor on ng the tour from t:10 p.m., carpet on the bottom third walls throughout			Identification of Other ResidentsAll residents have to potential to be affected by thi alleged deficient practice.III. Measures Put In PlaceIn the future, prior to the installation new carpet, the facility will rethe vendor to provide documentation of the flame spread rating. Maintenance keep copies of the document a binder.IV. Monitoring of Corrective ActionSafety Committee will monitor compliance by reviewing the documents in the Flame Spread ratine.	s of quire will s in	
	3.1-19(b)						
K0044 SS=E	with 7.2.4. 19.2. 1. Based on obinterview, the factors 1 of 4 final arranged to autonic 19.2.	eservation and acility failed to re door sets was comatically close 19.2.2.5 requires	K0	044	The door on 200 hall was adjusted and now closes and latches properly. 2. The	1. I	08/06/2011
	accordance with 7.2.4.3.8 requires	h 7.2.4 and res fire doors to be automatic closing in			service door between the kitch and main dining room will be replaced by 8-6-11.II. Identification of Other Residents 1. All residen have the potential to be affect	ts	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	I DING	01	COMPL	ETED
		155673	B. WIN			07/07/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIE	₹		1	RACY ST		
MARKLE	HEALTH & REHA	BILITATION		1	E, IN46770		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	addition NFPA	80, Standard for			by this alleged deficient practice. 2. All resident	s who	
	Fire Doors and Windows at				go to the dining room have t		
	2-1.4.1 requir	es all closing			potential to be affected by the		
	mechanisms s	hall be adjusted to			alleged deficient practice.III.		
	overcome fire	resistance of the				1.	
	latch mechanis	sm so positive			Maintenance personnel will all fire doors for proper closu		
		ieved on each door			one x weekly x 90 days and	ıı C	
	_	s deficient practice			document findings. Any ide	ntified	
	I -	y residents at the			issues will be immediately		
		tation and twenty			corrected. 2. A new doo		
		in the 200 hall.	been ordered and will be installed by 8-6-11. Door has the required 1 1/2 hour fire rating.IV. Monitoring of Corrective Action 1. Maintenance will report any non-compliance				
	Findings includ	de:				vill	
	Based on obse	rvation with the			immediately to facility ED/DNS 8		
	Environmental	Supervisor on			to the monthly Safety Committee. 2. Mainten	2000	
	07/07/11 at 1	2:35 p.m., the fire			will monitor for presence of t		
	doors entering	the 200 hall from			fire-rating tag on the dining r		
	the main nurse	es' station failed to			service door each month du		
	latch into the f	rame. Based on an			walking rounds. Maintenand	ce will	
	interview with	the Environmental			document compliance on a monthly CQI tool & present	o the	
	Supervisor at t	he time of			Safety Committee for review		
		nese doors were			recommendations.		
	confirmed to b						
	3.1-19(b)						
	interview, the ensure 1 of 2 s doors was pro appropriate fir	oservations and facility failed to single fire barrier vided with the e protection rating n in which they are					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155673	B. WIN			07/07/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
MADIZIE	LICALTH & DELIAD	DII ITATIONI		1	FACY ST	
	HEALTH & REHAE				.E, IN46770	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
		7.2.4 leads to LSC		-		
		requires openings				
	in fire barriers comply with LSC 8.2.3.2.3.1 which requires 1 1/2					
		hour fire barriers.				
		practice could affect				
		n the main dining				
	room.					
	Findings includ	le:				
	,					
	Based on an ob	servation with the				
	Environmental :	Supervisor on				
	07/07/11 at 1:	05 p.m., the service				
	door between t	he kitchen and				
	main dining roo	om was a nonrated				
	metal door. Ba	sed on an interview				
	with the Enviro	nmental Supervisor				
	at the time of c	bservation, the				
	door is in a two	hour fire wall.				
	Additionally, th	e door beside the				
	service door en	itering the kitchen				
	in the same two	o hour fire wall was				
	a one and one	half hour fire rated				
	door.					
	3.1-19(b)					
K0046	• • •	g of at least 1½ hour				
SS=F	duration is provide 19.2.9.1.	ed in accordance with 7.9.				
	19.2.9.1.					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	01	COMPI	LETED
		155673	B. WIN			07/07/2	2011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		170 N T	RACY ST		
MARKLE	HEALTH & REHAI	BILITATION		MARKL	E, IN46770		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)	17.0	TAG			DATE
	Based on obse		K	0046	K046It is the practice of this facility to ensure the periodic		08/06/2011
	interview, the facility failed to ensure 2 of 2 emergency light fixtures of at least 1½ hour			testing of emergency lighting is			
					performed at 30 day interval		
					a minimum of 30 seconds a	nd to	
	duration were tested monthly and				ensure an annual test is conducted on every battery		
	annually in accordance with LSC				powered emergency lighting	1	
	7.9. LSC 7.9.3	Periodic Testing of			system for no less than 1 1/2		
	Emergency Lig	hting Equipment			duration.l. Corrective Action		
	requires a fund	ctional test shall be			TakenEmergency lighting wa	as	
	conducted on	every required			tested for a minimum of 30 seconds.An annual test was		
	battery powere				conducted on every battery	•	
	1	n at 30 day intervals			powered emergency lighting)	
		of 30 seconds. An			system.II. Identification of C		
		all be conducted on			ResidentsResidents do not		
		battery powered			the potential to be affected to alleged deficient	by this	
		nting system for not			practice.Maintenance has be	een	
	less than 1 ½	- ·			re-instructed on the		
					requirements of conducting		
	Equipment sha				Periodic Testing of Emerger Lighting Equipment.III. Mea		
	I .	the duration of the			Put In PlaceMaintenance ha		
		ecords of visual			re-implemented a monthly		
	1	d tests shall be kept			monitoring sheet entitled		
	l '	or inspection by the			"Battery-Operated Emergen		
		ng jurisdiction. This			Lights-Test Log". Log will be completed each month.IV.	е	
	deficient pract	ice could affect all			Monitoring of Corrective		
	occupants.				ActionED/designee will mon	itor	
					compliance by reviewing this		
	Findings includ	de:			each month. ED/designee v		
					initial and date the log upon review. Any issues will be		
	Based on obse	rvation with			reported to the Safety Comr	nittee	
	Environmental	Supervisor on			for review and recommenda		
		:15 p.m. and 1:20					
	p.m., a battery	·					
	1 '	nt was observed at					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/07/2011
	PROVIDER OR SUPPLIER		170 N T	ADDRESS, CITY, STATE, ZIP CODE TRACY ST .E, IN46770	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0048 SS=F	powered emergobserved at the on an interview Environmental 07/07/11 at 11 were no written monthly tests, for the battery emergency light review. 3.1–19(b) There is a written patients and for the facility failed evacuation of the compartment in for the protection residents in the emergency. LSC written health casafety plan that a following: (1) Use of alarms	Supervisor on 1:18 a.m., there 1 records of 1 or an annual test, 1 operated 1 ts available for I olan for the protection of all 1 eir evacuation in the event 1 19.7.1.1 1 review and interview, 1 to include the 1 e smoke 1 the written fire plan 1 of 67 of 67 1 event of an 1 19.7.2.2 requires a 1 are occupancy fire 1 shall provide for the	K0048	K0048It is the practice of this facility to ensure there is a w plan for the protection of all patients and for their evacua in the event of an emergency Corrective ActionFacility has written plan which addresses evacuation of the smoke compartment.II. Identificatio Other ResidentsAll residents have the potential to be affect by this alleged deficient practice of the update to the emergency pla 8/6/11. Inservice will be	rritten stion y.l. a s the n of cted ctice. e

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155673		(X2) MULTIPLE C A. BUILDING B. WING	01	(X3) DATE COMP - 07/07/2	LETED	
	PROVIDER OR SUPPLIER		STREET 170 N	TADDRESS, CITY, STATE, ZIP COI TRACY ST (LE, IN46770	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	(6) Evacuation of (7) Preparation of for evacuation (8) Extinguishme This deficient proccupants. Findings include Based on a reviee Fire/Disaster/Satenvironmental Dat 11:50 a.m., the address the evacuompartment.	ire f immediate area f smoke compartment of floors and building ent of fire actice could affect all : w of the fety Plan with pirector on 07/07/11 ne fire plan did not cuation of the smoke This was y the Environmental		performed by the Main Director/designee.III. Put In PlaceFacility Fire/Disaster/Safety Placen updated to address evacuation of the smo compartment. IV. Mo Corrective Action Take Committee will periodi our Fire/Disaster/Safe updates.	Measures lan has ess the ke nitoring of enCQI cally review	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE S COMPL	
		155673	A. BUII			07/07/2	
			B. WIN		DDDDGG GWY GW	31,01,2	
NAME OF P	ROVIDER OR SUPPLIER			l	DDRESS, CITY, STATE, ZIP CODE		
MVDNIL	HEALTH & REHAE	RILITATION		l	RACY ST E, IN46770		
		-		<u> </u>	L, IIN4U//U		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
		· · · · · · · · · · · · · · · · · · ·	-	TAG	DEFICIENCY)		DATE
TAG K0051 SS=D	A fire alarm syster components, device according to NFPA Code, to provide eany part of the build complete fire alarm alarm initiation, au extinguishing system patient sleeping provided that man 200 feet of nurse's located in the path written records of reliable second so Fire alarm system accordance with N maintenance are kis remote annuncial system to an appropriate appropriate of 1 sthe 300 hall shinstalled where adversely affect Section 9.6.1.4 systems comply National Fire Alarchy air had detectors shall where air flow of the detectors.	ces or equipment is installed A 72, National Fire Alarm effective warning of fire in Iding. Activation of the many system is by manual fire atomatic detection or emoperation. Pull stations areas may be omitted ual pull stations are within a stations. Pull stations are not egress. Electronic or tests are available. A surce of power is provided. IFPA 72 and records of sept readily available. There ation of the fire alarm oved central station. Tration and facility failed to moke detectors in ower room was air flow would not to its operation. Trequires fire alarm y with NFPA 72, larm Code. NFPA quires in spaces andling systems, not be located prevents operation s. This deficient affect any residents.	KO	0051	K0051It is the practice of this facility to ensure all smoke detectors are installed where flow does not adversely affect operation of the detectors. I. Corrective Action TakenThe smoke detector is positioned where the air flow does not adversely affect the operation of the detector. II. Identification Other Residents All residents use the 300 hall shower room have the potential to be affect by this alleged deficient practical All smoke detectors in the fact were checked for proper placement on 7-19-11. No of detectors were found to be improperly placed. III. Measur Put in PlaceThe smoke detectors was relocated on 7-19-11. IV.	air to the n of of who n ted tice. cility ther	08/06/2011
					Monitoring of Corrective Action	J11	
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID: Y	QU21	Facility I	D: 000544 If continuation sh	neet Pag	ge 9 of 22

Event ID: YIQU21

Facility ID:

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/07/2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN46770		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0062 SS=D	Environmental 207/07/11 at 12 smoke detector shower room we three feet of a 2 This was acknown Environmental 2 time of observations and are periodically. 19. 25, 9.7.5 1. Based on observations and are periodically. 19. 25, 9.7.5 1. Based on observations and are periodically. 19. 25, 9.7.5 1. Based on observations are the spragary that sprinkler heads in the Social Segon. 5 requires a sprinkler system and maintained NFPA 25, Standinspection, Tes	servation with the Supervisor on 2:01 p.m., the in the 300 hall as located within air supply duct. wledged by the Supervisor at the ation. It sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA asservation and acility failed to by pattern for 1 of 1 as was unobstructed rvice office. LSC all automatic in spected and tested 1 in accordance with ard for the ting and 5 Water-Based Fire terms. NFPA 25,	K0062	TakenMaintenance will monimonthly during facility rounds report non-compliance during monthly Safety Committee meeting. K0062It is the practice of this facility to ensure automatic sprinkler systems are continuously maintained in reliable operating condition a are inspected and tested periodically.I. Corrective Act 1. Sprinkler head in So Services office is now unobstructed. 2. There trace of paint on the sprinkle head in the laundry room.II. Identification of Oth Residents 1. Residents frequent the Social Services Office could be affected by the alleged deficient practice.	s and g the 08/06/2011 and cion cial is no r er who

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 01	(X3) DATE COMPI 07/07/2	LETED
		155673	B. WIN			07/07/2	UII
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE TRACY ST		
MARKLE	HEALTH & REHAE	BILITATION		1	E, IN46770		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	unacceptable of spray patterns. This deficient pany residents in office. Findings include Based on observations and office and offi	bstructions to shall be corrected. bractice could affect in the Social Service e: vation with the Supervisor on 2:51 p.m., the spray sprinkler head in ce office was a ceiling light sides of the This was by the Supervisor at the ation. pservation and acility failed to sprinklers in the ad been painted in om behind the 7.5 requires all akler systems shall and maintained in h NFPA 25, e Inspection,			No residents are affected be alleged deficient practice. If Measures Put in Place Sprinkler head will be lower 8/6/11. 2. Sprinkler heads be replaced by 8/6/11.IV. Monitoring of Corrective Acc. 1 & 2. Maintenance with monitor for the presence of on sprinkler heads immediated after any area in the facility been re-painted. All non-compliance will be procorrected and reported to the facility ED/designee for follows:	II. 1. ed by ad will tion ill paint tely has	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	onstruction 01	(X3) DATE SURVEY COMPLETED
		155673	A. BUILDING B. WING		07/07/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
MARKLE	HEALTH & REHAB	BILITATION	l l	E, IN46770	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	Water-Based Fi				
	•	25, 1998 edition,			
	·	es any sprinkler ed which is painted,			
	-	aged, loaded, or in			
		rientation. This			
	deficient practi				
	resident care a	rea but could affect			
	any number of	staff.			
	Findings include:				
	Based on observation with the				
	Environmental	Supervisor on			
	07/07/11 at 1:	15 p.m., there was			
	paint on the de	flector of the			
		r head behind the			
	-	as acknowledged by			
		ntal Supervisor at			
	the time of the	observation.			
	3.1-19(b)				
K0064 SS=D	health care occupa	guishers are provided in all ancies in accordance with 5, NFPA 10			
	Based on obser		K0064	K064It is the practice of this	08/06/2011
	interview, the f	acility failed to		facility to inspect fire extinguishers at least monthl	v
	inspect 3 of 3 f	ire extinguishers in		with the date of the inspection	
	the kitchen and	d 1 of 1 laundry		and the initials of the person	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 01	(X3) DATE COMPI				
AND I LAN OF CORRECT	ON	155673		LDING	01	07/07/2			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER				1	TRACY ST				
MARKLE HEALTH 8	REHA	BILITATION		1	E, IN46770				
` '		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
,		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE		
		nguishers each	+	IAG	performing the inspection		DATE		
		10, Standard for			recorded.I. Corrective Action	า			
I		xtinguishers,			TakenThe fire extinguishers				
I		2 requires fire			kitchen have been inspected fire extinguisher in the laund				
I		requires fire rspections at least			has been inspected.II.	· y			
I -		he date of			Identification of Other				
1 '		the initials of the			ResidentsMaintenance direct has been instructed on the	tor			
I		ning being			responsibility of inspecting fi	re			
· · · · · · ·		ddition, NFPA 10,			extinguishers each month.				
I		defines inspection			Instruction was completed by 8-6-11.III. Measures Put in	y			
		eck" to ensure the			PlaceMaintenance performs	an			
· ·		er is available and		inspection of all fire exguishers on					
	_	t is intended to give			a monthly basis. All extingui	shers			
		surance the fire			will be inspected prior to the Monthly Safety Committee				
extingui	sher is	fully charged and			Meeting. IV. Monitoring of				
operable	e, verif	ying it is in its			Corrrective Action Monitoring	g will			
designa	ted pla	ce, it has not been			be done by completion of a monthly CQI tool. Maintena	100			
actuated	or tai	mpered with and			will complete the tool and re				
there is	no obv	vious or physical			compliance during the month	nly			
damage	or cor	ndition to prevent its			Safety Committee meeting.				
operatio	n. Th	s deficient practice							
could af	fect ar	y number of kitchen							
and laur	ndry st	aff.							
Et alt an		1.							
Findings	inciu	ue.							
Based o	n obse	rvations with the							
Environr	nental	Supervisor on							
07/07/1	1 fron	n 1:13 p.m. to 1:17							
p.m., th	e mon	thly inspection tag							
		fire extinguisher							
		entation of a							
monthly	inspe	ction since April							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155673		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 01	(X3) DATE S COMPL 07/07/2	ETED	
	PROVIDER OR SUPPLIER		<i>p.</i> where	STREET A	ADDRESS, CITY, STATE, ZIP CODE TRACY ST E, IN46770	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0067 SS=E	tags for the threextinguishers in documentation inspection for the 2011. This was the Environment the time of observation of the time of observation of the time of observation of Air-Condition Ventilating Systems and provided of Air-Condition o	of a monthly the month of June, s acknowledged by ntal Supervisor at ervations. g, and air conditioning ovisions of section 9.2 and cordance with the ecifications. 19.5.2.1, 9.2, 2.2 vation and acility failed to campers in the em was inspected ecessary c least every four ance with NFPA requires air eating, ventilating elated equipment ordance with NFPA for the Installation	K0	067	F067It is the practice of this facility to ensure the heating ventilating, and air conditioni comply with the provisions of section 9.2 and are installed accordance with the manufacturer's specifications. Corrective Action TakenThe damper at the 300 hall fire by wall was inspected on 7/24/1 Identification of Other Residents All residents on 30 have the potential to be affect by this alleged deficient pract Maintenance has been instruction the requirements to perform an inspection of the dampers Instruction was completed by 8/2/11.III. Measures Put In PlaceMaintenance will compute "Fire/Smoke Damper Maintenance Record" upon	ng f in s.l. s.l. fire arrier 11.ll. 0 hall cted tice. ucted rm s.	08/06/2011

000544

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	155673	A. BUILDING	01	. 07/07/2	
		100070	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COL	DE .	
MARKI F	HEALTH & REHAE	BILITATION		TRACY ST _E, IN46770		
				,		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOWN		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
	dampers shall l			testing of the fire damp	ers.IV.	
		close; the latch, if		Monitoring of Correctiv		
		be checked, and		ED/designee will monit initialing the "Fire/Smo		
	· ·	hall be lubricated		Maintenance Record"		
	as necessary.			completed.		
	practice affects					
	residents on 30	·				
	Findings includ	le:				
	.					
	Based on obser	vation with the				
	Environmental	Supervisor on				
	07/07/11 at 2:	05 p.m., there was				
		n the ventilation				
	-	ire barrier wall of				
	the 300 hall. B	ased on interview				
	with the Enviro	nmental Supervisor				
	on 07/07/11 a	t 2:30 p.m., he was				
	not aware of th	e damper and was				
	unable to provi	de documentation				
	to show the da	mper had been				
	inspected.					
	3.1-19(b)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			ETED	
		155673	B. WING			07/07/2	011
	PROVIDER OR SUPPLIER		•	170 N T	DDRESS, CITY, STATE, ZIP CODE RACY ST E, IN46770		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE
K0074 SS=F	Draperies, curtains and other loosely is serving as furnishicare occupancies provisions of 10.3. for the Installation Shower curtains a 701. Newly introduced health care occups specified when tes methods cited in 119.7.5.1, NFPA 13 Newly introduced specified when tes method cited in 10 Based on observinterview, the fensure window 49 resident roor retardant. This could affect all Findings include Based on observinterview, the fensure window 19 resident roor retardant. This could affect all provides a provide the servinter of	s, including cubicle curtains, hanging fabrics and films ings or decorations in health are in accordance with .1 and NFPA 13, Standards of Sprinkler Systems. The in accordance with NFPA upholstered furniture within ancies meets the criteria sted in accordance with the 10.3.2 (2) and 10.3.3. In mattresses meet the criteria sted in accordance with the 10.3.2 (3), 10.3.4. 19.7.5.3 revation and facility failed to a curtains in 49 of the same of deficient practice residents. Ite: The value of the supervisor on the 11:53 a.m. to 2:10 the coverings in all rooms lacked	K0	074	K074It is the practice of this facility to ensure draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films ser as furnishings or decorations health care occupancies are accordance with provisions of 10.3.1 and NFPA 13, Standa for the installation of Sprinkle Systems.I. Corrective Action TakenFacility has obtained documentation concerning the flame spread rating of the curtains in resident rooms.II. Identification of Other ResidentsAll resident rooms the potential to be affected by alleged deficient practice.	s in in in of rds er he have y this	08/06/2011
		y were inherently			Maintenance has been instrute to obtain a copy of the flame	iciea	
	flame retardant	t. Based on			spread rating when purchasing		
	interview with t	the Environmental			curtains or other fabric items	-	
	Supervisor at 1	2:40 p.m.,			Instruction took place by		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155673	B. WING		07/07/2011
	ROVIDER OR SUPPLIER		170 N	ADDRESS, CITY, STATE, ZIP CODE TRACY ST	1
WARKLE	HEALTH & REHAB	BILITATION	IVIARKI	_E, IN46770	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	documentation	regarding the		8/2/11.III. Measures Put in PlaceIn the future, prior to	
	flame retardance	cy for these window		purchasing new curtains, the	_
	coverings was i	not available for		facility will require the vendo	l l
	review.			provide documentation of the	
	3.1-19(b)			flame spread rating. Maintenance will keep copie the documents in a binder.IV Monitoring of Corrective ActionSafety Committee will monitor compliance by reviethe documents in the Flame Spread Binder each quarter.	s of /. wing
K0076 SS=E		ge and administration areas ocordance with NFPA 99, lth Care Facilities.			
		e locations of greater than closed by a one-hour			
		upply systems of greater re vented to the outside.			
	Based on obser	vation and	K0076	F076It is the practice of this	08/06/2011
	interview, the fa	acility failed to		facility to ensure medical gas storage and administration a	
	ensure combus	tible materials were		are protected in accordance	
	separated from	oxygen storage		NFPA 99, Standards for Hea	l l
	equipment in 1			Care Facilities.I. Corrective	
	storage areas.	· -		Action TakenThe combustible	
	-	ealth Care Facilities,		materials were removed from Oxygen storage area.II.	n the
		<i>'</i>		Identification of Other	
	Section 8-3.1.11.2(c)2 requires oxidizing gases such as oxygen			ResidentsResidents affected	- I
	shall be separa			this alleged deficient practice	• • • • • • • • • • • • • • • • • • •
	combustibles b			those at the nurses station.A staff will be inserviced about	
	distance of five			storing combustible materials	I
		•		the Oxygen Storage area.	
	sprinklered bui	_		Inservice will be completed of	on
	deficient practi	ce affects residents		8/6/11.III. Measures Put In	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	(X2) MULTIPLE CONSTRUCTION 01			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155673	a. BUILDING 01		<u> </u>	- 07/07/2011	
		155673	B. WIN			07/07/20	JII
NAME OF I	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
MADKIE	HEALTH & REHAB	ULITATION			RACY ST E, IN46770		
					E, 1140770		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	at the main nur	·	+	1110	PlaceMaintenance will check	the	DATE
	Findings includ				Oxygen Storage Area each week x 3 months. Checks will be documented on a CQI tool and		
	Based on an observation with the Environmental Supervisor on 07/07/11 at 11:58 a.m., combustible material such as cardboard boxes and plastic items were stored within three feet of stationary liquid oxygen containers in the oxygen storage room. This was acknowledged by the Environmental Supervisor at the time of observation.				provided to the ED/designee Monitoring of Corrective Action Results will be presented to Safety Committee Meeting e month for follow up and recommendations.	on	
K0130 SS=E		ICIENCY NOT ON 2786	W	120	K420It is the practice of this		00/07/2011
	Based on observation and interview, the facility failed to ensure 4 of 14 penetrations of the fire barrier walls were protected by an approved device designed for the specific purpose and capable of maintaining the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC		K	1130	K130lt is the practice of this facility to ensure penetrations the fire barrier walls are prote by an approved device desig for the specific purpose and capable of maintaining the fir resistance of the barrier.l. Corrective Action Takena) the area in the drop down ceiling the 100 hall fire wall has bee repaired by using a fire resist material.b) the area in the 30 hall attic fire barrier around the telephone line has been repaired by using a fire resistant material.c) the area in the Augusta's Cottage attic fire	ected ined re e j at n tant 00	08/06/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155673		(X2) MULTIF		NSTRUCTION 01	(X3) DATE S COMPL	ETED	
		155673	B. WING			07/07/2	U11
	PROVIDER OR SUPPLIER E HEALTH & REHAE		17	'0 N TI	DDRESS, CITY, STATE, ZIP CODE RACY ST E, IN46770		
(X4) ID PREFIX TAG	REGULATORY OR 8.2.3.2.4.2 req conduits, bus of air ducts, pneuducts, and simile equipment that barriers shall be follows: (1) The space be penetrating ite barrier shall me following condua. It shall be fill that is capable fire resistance be. It shall be prapproved device for the specific (2) Where the puses a sleeve to barrier, the slees at in the fire be space between sleeve shall me following condua. It shall be fill that is capable fire resistance be shall me following condua. It shall be fill that is capable fire resistance be. It shall be prapproved device to the specific for the specif	ducts, cables, wires, matic tubes and flar building service a pass through fire the protected as the protected by an the protected by an the protected by an the protected by an the protected be solidly parrier, and the protected and t	ID PREF	FIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) barrier wall around an intern wire has been repaired by us fire resistant material.d) the a in the service hall attic fire waround the main sprinkler limbeen repaired by using a fire resistant material.II. Identification of Other Reside All residents have the potent be affected by this alleged deficient practice. Maintenar was educated about preventipenetrations of the fire barrie walls. Education was compleby 8/6/11.III. Measures Put I PlaceAfter the facility has an type of work performed by contractors, maintenance will promptly inspect the fire wall the attic and above the drop ceiling for the presence of an unsealed penetrations. Inspection by maintenance we performed within 7 days of contractor's completion of job Monitoring of Corrective ActionResults of Maintenanc Inspections will be reported to monthly Safety Committee Meeting for review and recommendations.	et sing a area all e has ents ial to nce ing er eted n y l s in etel out	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAIN	OF CORRECTION	155673	A. BUI		01	07/07/2011	
		100010	B. WIN		PRESIDENCE CONTROL CON	0770772011	
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE RACY ST		
MARKLE HEALTH & REHABILITATION				1	E, IN46770		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	$\overline{}$
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Findings includ	e:					
	Based on obser	vations with the					
	Environmental :	Supervisor on					
	07/07/11 from	1:50 p.m. and					
	2:10 p.m., the	following fire walls					
	had unsealed p	enetrations:					
	a) above the di	rop down ceiling at					
	the 100 hall fire	e wall there was					
	one of seven pe	enetrations					
	measuring thre	e fourths inch					
	around the mai	n sprinkler line.					
	b) in the 300 h	all attic fire barrier					
	one of four pen	netrations					
	measuring one	inch around the					
	telephone line						
		sta Cottage attic					
	fire barrier wall						
	penetration me	asuring two inches					
	around a Intern						
	d) in the servic	e hall attic fire wall					
	one of two pen						
	-	inches around the					
	main sprinkler						
	Based on an int						
		Supervisor at the					
		ations, the walls					
	were fire barrie						
	baille						
	3.1-19(b)						
K0147 SS=E	Electrical wiring ar accordance with N Code. 9.1.2	nd equipment is in IFPA 70, National Electrical					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155673		A. BUI	LDING	ONSTRUCTION 01	(X3) DATE (COMPL) 07/07/2	ETED	
AND PLAN	PROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OR Based on obser interview, the f ensure 1 of 1 fl as an extension as a substitute LSC 19.5.1 requires of equipment to comply with Se	ISILITATION TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) TVATION AND acility failed to lexible cords such n cord was not used for fixed wiring. uires utilities to	A. BUII	LDING G STREET A 170 N	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) K147It is the practice of this facility to ensure electrical wand equipment is in accorda with NFPA 70, National Electrode. 9.1.2.I. Corrective Action Should be cross-referenced to the facility to ensure electrical wand equipment is in accorda with NFPA 70, National Electrode. 9.1.2.I. Corrective Action TakenThe extension cord waremoved from the employee break room.II. Identification Other ResidentsNo resident were affected by this alleged deficient practice. Staff was inserviced about extension cords. Inservice was comple	o7/07/2	ETED
	Edition. NFPA requires, unles permitted, flex cables shall no substitute for f structure. This was not in a res	70, Article 400–8 s specifically ible cords and t be used as a ixed wiring of a deficient practice sident care area but y number of staff.			8/6/11.III. Measures Put In PlaceMaintenance will chec the presence of extension of weekly x 3 months. Rounds be documented on a CQI form.IV. Monitoring of Corresponding to the monthly Safety Committen review and recommendation	k for ords will ective ed to ee for	
	Based on an ob Environmental 07/07/11 at 1: extension cord and providing p microwave in the	servation with the Supervisor on 10 p.m., an was plugged in bower for a ne employee's vas acknowledged mental Supervisor at					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMP 07/07/2	LETED
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP C		
MARKLE	HEALTH & REHAE	BILITATION	MARKL	E, IN46770		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE